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REHABILITATION POTENTIAL AS THE BASIS OF THE PROCESS OF RESOCIALIZATION AND SOCIAL ADAPTATION OF YOUNG PERSONS AFTER ISCHEMIC STROKE (Literature Review)

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ABSTRACT
Nowadays stroke is still a completely unresolved problem of the modern medical community, leading to a high percentage of death, and in case of survival - to disability. Disability after suffering a brain accident occupies a leading position among all causes of disability in patients, which significantly worsens the quality of life of patients and complicates the process of their resocialization and social adaptation. This article is devoted to the concept, principles and criteria of rehabilitation potential, as well as factors influencing it.
KEYWORDS: *ischemic stroke, young age, resocialization, social adaptation, rehabilitation potential.*

Recently, in modern society, the problem of socialization and social adaptation of young patients who have had ischemic stroke has become of great relevance. (1).

Persons of working age after suffering a brain accident face a number of problems that can lead to their complete desocialization due to social and mental self-isolation due to the remaining neurological deficit. In this regard, close attention is paid to the study of the process of resocialization (1,2).

Resocialization is one of the aspects of rehabilitation, which is based on the process of mastering social norms (3), as well as restoring lost or strengthening weakened functions, including social (4). E. Giddens defined the process of resocialization as one of the types of personal change, as a result of which a person becomes characterized by behavior that differs significantly from the previous one. (5,6).

For the process of resocialization, the completeness of the use of the technology of rehabilitation measures is of great importance, which not only contribute to the restoration of lost skills and abilities, but also accelerates the resocialization and social adaptation of patients.

One of the main components of the resocialization process is the determination of the rehabilitation potential, which is formed from 4 aspects: medical (degree of restoration and compensation for lost functions), psychological (state of psychological status), social (restoration of everyday and professional skills) and family and public (degree of restoration of social connections) (2,7).

Many researchers consider the rehabilitation potential as a complex of psycho-physiological properties of a sick person, his illness and its consequences for the body. According to Gitkina L.S. et al. (1999), rehabilitation potential is an integral indicator of taking into account the reserve capabilities of the body, the potential of the patient's personality and the influence of his environment on the process of restoring functional capabilities, daily activities and professional suitability of the patient. Korolev A.A. et al. (2014) defined the rehabilitation potential as a reasonable probability of achieving the intended goals of medical rehabilitation in the planned period of time, taking into account the nature of the disease, its course, individual resources and compensatory capabilities while maintaining a stable somatic and mental state of the patient, his high motivation in relation to the upcoming rehabilitation treatment (7,8). Sokrut (2015), in turn, considers this issue as a reflection of the ability of patients to endure various rehabilitation measures and achieve the highest possible level of restoration of lost functions (9).

In 1973 Belov V.P. and Efimov I.N., they were the first to propose the use of the term "rehabilitation potential" and defined it as a complex of biopersonal and socio-environmental factors that form the basis of the patient's resocialization (10).

Korobov M.V. spoke about the rehabilitation potential as the patient's ability, under specific conditions and with appropriate support, to launch the biological and psycho-sociological reserves of adaptive-compensatory processes and mechanisms underlying the restoration of impaired health, disability and social status (11).

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In general, the potential for resocialization is an indicator that assesses the capabilities of a diseased organism and the influence of various factors on the restoration of lost functions, household and professional skills, and social adaptation.

RP consists of 6 components (12,13,14), which include:

1. Basic anatomical and physiological component, consisting of an assessment of the degree of physical development and performance, mental and physiological endurance, psycho-emotional stability.
2. Psychophysiological component - a complex of unaffected functions and personality traits, determined during testing by the method of functional loads and pharmacological tests, as well as methods of functional diagnostics.
3. The professional labor component is defined as the possibility of restoring professional status and professional skills and adapting to work.
4. The educational component is the restoration of the ability to possess knowledge, skills and abilities in the field of one's professional activity.
5. Socio-environmental component - the ability to carry out independent household and social activities.
6. Social and household component - restoration of self-service skills.

There are 4 levels of rehabilitation potential:

High RP – the probability of a complete restoration of health, all types of life, working capacity and social status, or partial restoration of a lost function with full household, social and professional adaptation.

Average RP – the probability of maintaining a neurological deficit of mild or moderate degree with incomplete recovery of working capacity and the need for outside assistance (group III disability).

Low RP – a pronounced neurological deficit persists, all types of life activities are significantly limited, with the restoration of self-service skills.

RP is absent while maintaining a pronounced neurological deficit, inability to self-service and lack of labor and professional adaptation.

The degree of rehabilitation potential is influenced by a variety of factors that can be grouped into 3 groups:

1. medical factors,
2. social factors,
3. psychological factors.

Of great importance in determining the RP of patients with ischemic stroke at the inpatient stage of rehabilitation are medical factors, namely:

- localization and size of the ischemic focus. It has been established that with damage to the cortex or the adjacent subcortical one, there is a possibility of a high RP than with damage to deep structures. But even with a minimal lesion in the area of the medulla oblongata or internal capsule, as well as with extensive damage to the right or left hemisphere in the basin of the cerebral artery, there is a persistent neurological deficit, which indicates a low RP;
- the severity of the course of IS, the nature and severity of the neurological deficit and cerebral symptoms, the presence of polysyndromicity (impairment of the motor and sensory spheres, speech disorders, etc.). At the same time, the severity of symptoms is directly dependent on the location and size of the pathological focus;
- indication of pre-stroke transient ischemic attacks or transient cerebrovascular accident;
- the presence and severity of one or more background diseases such as cerebral atherosclerosis, arterial hypertension, coronary heart disease, diabetes mellitus, alcoholism, vasculitis, etc.
- organization of the rehabilitation process: stages and the beginning of rehabilitation activities, duration and continuity.

When assessing “rehabilitation potential”, rehabilitators use the International Classification of Functioning, Disabilities and Health, which was approved by WHO member countries at the 54th World Health Assembly on May 22, 2001 (WHA Resolution, 2001). This classification describes health domains and health-related domains, which include two main lists: 1. body functions and structures and 2. activity (15).

Many scientists and specialists distinguish 3 degrees of rehabilitation potential: high, medium and low.

High potential criteria are:

1. partially or completely reversible processes of neurological deficit;
2. harmonic or ergopathic type of attitude towards the disease in combination with an open personality behavior;
3. there is a complete restoration of former social roles;
4. family members have irregular employment, a general readiness for the implementation of rehabilitation measures and the environmental availability of rehabilitation funds.

The average rehabilitation potential is determined, in the case of:

1. maintaining moderate or mild impairment of neurological function in the patient;
2. sensitive and hypochondriacal type of attitude to the disease and the absence of pronounced character traits and behavioral patterns in the patient;
3. partial restoration of the patient's former social roles;
4. lack of accessibility of the environment, but in the presence of other indicators of family and social rehabilitation.

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The low rehabilitation potential is determined when:

1. the preservation of a pronounced functional defect in the patient is predicted;
2. there is a non-adaptive attitude to the disease in combination with a hidden, distrustful behavior of the patient;
3. there is an inability to return to the performance of previous social roles, as well as to adapt to modified circumstances;
4. the patient's family members do not have the opportunity to work in an irregular mode, or she is not ready to carry out rehabilitation measures to cure her relative.

Thus, the assessment of the rehabilitation potential in the acute period of ischemic stroke gives us the opportunity to predict the outcome, an individual differentiated approach to rehabilitation treatment, the selection of adequate rehabilitation measures and, accordingly, determine the quality of life of such patients.

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